



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

MEDALERT OCCUPATIONAL MANAGEMENT INC

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-14-3528-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 31, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Norma Pacheco, with Ponce Contractors initially asked for these bills to be sent directly to the company for payment. The original bills were sent to Ponce Contractors on September 25, 2013. It was not until February 13, 2014 that Norma advised me that she had turned this injury over to Texas Mutual for processing; The bills were immediately submitted through Jopari on February 14, 2014."

**Amount in Dispute:** \$326.02

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute of 9/20/2013 and 9/23/2013... MEDALERT OCCUPATIONAL MANAGEMENT INC reports it submitted it bills to the employer at his request. Apparently, the employer failed to follow and pay or forward to Texas Mutual... The rationale given by the requestor for the late bill does not fall under the exception criteria of 408.0272 of the Labor code. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2013 and September 23, 2013	99203, 99080-73 x 2 and 99213	\$326.02	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Issue**

Did the requestor waive the right to medical fee dispute resolution?

### **Findings**

Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bills for the services in dispute to the injured worker's employer. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

### **Conclusion**

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties, and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

_____	_____	November 20, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**